North Carolina Department of Health and Human Services
Medicaid Provider Change Form

For assistance completing this application, please call the CSC EVC Operations Center at 866-844-1113.

Items 1 and 5 are required. Complete other information only if there is a change. **(Please print.)**

For DMA/Fiscal Agent Use Only
Date Keyed: _____

1. Provider Information

Provider Name		
Medicaid Provider Number (*One provider number per form*)	NPI (*One NPI per form*)	Effective Date of Change
Type of Provider		
☐ Individual ☐ Group ☐ Carolina ACCESS		

2. Type of Change

☐ **Office (Site) Location**

Address (*Attach copy of new Provider Administrative Participation Agreement.*)			
City	State	ZIP Code + Plus 4 (*Required*)	County (*Required)*
Fax #		Office/Site Phone	E-mail (*Required)*

☐ **Billing Location**

Address			
City	State	ZIP Code + Plus 4 (*Required*)	
Fax #		Billing/Mailing/Payment/ Accounting Phone:	E-mail (*Required)*

☐ **NPI** (*Attach copy of NPPES reflecting NPI change.*)

Previous NPI:_____ **New NPI:** _____

☐ **Individual Provider Name** (*Attach a copy of your new license or certification reflecting your name change.*)

Previous Full Name: _____ **New Full Name:** _____

☐ **Individual Provider Tax Name** (*Attach a copy of your new license or certification reflecting your name change.)*

Previous Tax Name: _____ **New Tax Name:** _____

☐ **Individual Provider Tax ID**

Previous Tax ID: _____ **New Tax ID/SSN:**_____

Mail this form to: CSC EVC Operations Center, P.O. Box 300020, Raleigh, NC 27622-8020 or fax to 866-844-1382.

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☐ **Add or** ☐ **Delete Individual to/from a Group**
(The Group's name and provider number must be entered in Item 1. When adding an individual provider to your Group, attach a Group ECS Agreement with the new individual's provider name, individual N.C. Medicaid Provider Number, and signature entered in the Group Practice Member Information section.)

First Name, Last Name (Required):	Individual N.C. Medicaid Provider Number (Required):	Individual Medical License Number (CA Providers Only):

☐ **Change in bed capacity from ____ beds to ____ beds** *(Attach state license reflecting bed capacity change.)*
☐ **Change in Residential Child Care Treatment Level**
(Attach state license and Letter of Endorsement reflecting treatment level change.)
☐ **Change in Provider Specialty** *(Attach new license and letter requesting new specialty.)*
☐ **CLIA Certification Renewal** (*Attach a copy of your renewed CLIA certificate.)*
☐ **DEA Certification Renewal (***Attach a copy of your renewed DEA certificate.)*
☐ **Terminate Medicaid participation due to:** ☐ **Change of Ownership** ☐ **Other:** _____
(Attach a letter on letterhead requesting termination.)

3. Changes for Carolina ACCESS Providers only:

☐ **Change CA practice provider number to:** _____
Reason: _____
☐ **Change in contact person's name:** _____
☐ **After-hours phone:** _____
☐ **Change enrollment restriction information** (*i.e., ages 15 and up only):* _____
☐ **Change enrollment limit from:** _____ **to:** _____
☐ **Add counties served:** _____
☐ **Delete counties served**: _____ ☐ **Other:** _____

4. CABHA Affiliation Changes only:

☐ **Add (affiliate) an individual** outpatient therapy practitioner, physician, or advanced practice nurse to the CABHA.

Provider Name	Medicaid Provider Number	NPI	Start Date

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be added.

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

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☐ **Delete (unaffiliate) an individual** outpatient therapy practitioner, physician, or advanced practice nurse from the CABHA.

Provider Name	Medicaid Provider Number	NPI	End Date

Please identify the CABHA service provided by the individual outpatient therapy practitioner, physician, or advanced practice nurse to be deleted.

☐ Outpatient Therapy ☐ Medication Management ☐ Comprehensive Clinical Assessment

☐ **Add (affiliate) an attending service** to be provided by the CABHA.
To add an attending provider for a service, please complete the CABHA Addendum to Add Attending Services at http://www.nctracks.nc.gov/provider/providerEnrollment/.

☐ **Delete (unaffiliate) an attending service** provided by the CABHA.

Attending Provider Name	Medicaid Provider Number	NPI	End Date

Please identify the CABHA service provided by the attending provider to be deleted.

☐ Assertive Community Treatment Team
☐ Child and Adolescent Day Treatment
☐ Child Residential Level II-Family/Program Type, III, or IV
☐ Community Support Team
☐ Intensive In-Home
☐ Multi-Systemic Therapy
☐ Opioid Treatment
☐ Partial Hospitalization
☐ Psychosocial Rehabilitation
☐ Substance Abuse Comprehensive Outpatient Treatment Program
☐ Substance Abuse Intensive Outpatient Program
☐ Substance Abuse Medically Monitored Community Residential Treatment
☐ Substance Abuse Non-Medical Community Residential Treatment
☐ Therapeutic Family Services
☐ Targeted Case Management for Mental Health and Substance Abuse
☐ Peer Support

5. Signature

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual provider changes must have the provider's signature. Authorized agents can only sign for a group change.

Signature of Individual or Authorized Agent _____ Date _____

Printed Name _____ Title _____ Phone Number _____